



Helpful hints for filing

Miscellaneous CPT® coding

Overview

The following information provides general guidelines regarding the use of miscellaneous CPT/HCPCS level I codes for reporting the provision of health-care services, and supplements the general Helpful Hints for filing Current Procedural Terminology (CPT) codes. Coding, coverage, and documentation guidelines are listed on these pages. For information regarding specific reimbursement guidelines, including coding, coverage, and payment, please consult your local payer, the *Federal Register*, or the *Current Procedural Terminology, Fourth Edition (CPT)*.

Definitions

CPT/HCPCS level I procedure codes

Current Procedural Terminology (CPT), Fourth Edition is a systematic listing of codes, descriptions, and guidelines intended to describe services and procedures performed by physicians and other healthcare providers.¹ Each procedure or service is identified with a five-digit code. The CPT system is divided into procedure categories, such as surgical, laboratory, and anesthesia. Within these categories, the codes are organized by body system, and many of these categories contain miscellaneous codes to describe unlisted procedures or services.

Example: The CPT code for a single-determination pulse oximetry procedure is 94760 *Noninvasive ear or pulse oximetry for oxygen saturation; single determination.*

Miscellaneous code

A miscellaneous code is used for procedures, devices, and services that have not been assigned a unique CPT code.

¹Current Procedural Terminology (CPT), Fourth Edition, 2009. © 2008, American Medical Association.

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General coverage guidelines

Miscellaneous codes are used to report procedures involving new technologies, or unique or rare services, and always require additional documentation. The following table contains some examples of miscellaneous codes.

Relevant miscellaneous CPT codes

Code	Description
99499	Unlisted evaluation and management service
90899	Unlisted psychiatric service or procedure
94799	Unlisted pulmonary service or procedure
95999	Unlisted neurological or neuromuscular diagnostic procedure
99090	Analysis of clinical data stored in computers (e.g., ECGs, blood pressures, hematologic data)

Suggested documentation and claims filing procedure

Use of miscellaneous coding requires special claims filing procedures. Submitting claims through a manual process is recommended, as supporting documentation is necessary to supplement miscellaneous CPT codes.

Supporting documentation includes:

- Literature describing the procedure or service provided
- Letter of medical necessity signed by physician outlining the patient's diagnosis, overview of patient's condition and medical history, and clinical need for the procedure/service
- Clinical studies demonstrating the efficacy and safety of the procedure/service may also be helpful to provide with the claim

Some private payers may require prior authorization for procedures and services reported with miscellaneous codes.

Appealing denied claims

When using miscellaneous coding to report services, some claims may be denied. Claim denials may be due to lack of supporting documentation, payer processing errors, or specific restrictions in a patient's policy. If a claim denial is received, it is important to resubmit the claim for consideration.

In this instance:

- The **payer should be contacted** to clarify the reason for the denial. This is a good approach that may uncover a payer processing error, allowing the claim to be reconsidered without requiring actual resubmission.
- The **payer may require more information** describing the procedure performed or the patient's condition to properly process the claim. In these cases, it is important to include adequately detailed documentation with the claim resubmission.

If after filing the denial appeal you believe a claim denial has not been appropriately resolved, you should contact the payer's medical director.

Cost and charge considerations

Miscellaneous codes do not have set payment amounts attached to them. Payers will often conduct a manual review of claims with miscellaneous coding to determine an appropriate payment amount for the procedure or service in question. When determining the charge, you may want to consider the following factors:

- Level of resources used
- Cost of related equipment and supplies
- Complexity of the service
- Physician and staff time
- Malpractice risk expense
- Cost of living in your area

This information should not be considered to be either legal or reimbursement advice. Given the rapid and constant change in public and private reimbursement, Philips Respironics cannot guarantee the accuracy or timeliness of this information and urges you to seek your own counsel and experts for guidance related to reimbursement, including coverage, coding and payment.

For more information from Philips Respironics

Reimbursement	Customer service	Website
Information & fee schedules Educational materials & questions (coding, coverage and payment)	1-800-345-6443; listen to the instructions and follow prompts to select the insurance reimbursement information option	www.philips.com/respironics

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